ALL THIS AMOUNTS TO POORER HOUSING, UNSAFE LIVING ENVIRONMENTS, ... POORER HEALTH FOR AMERICA'S ADOLESCENTS.....

MORE STRESS ON FAMILIES.

AND THIS COMES AT A TIME WHEN FAMILIES ARE LESS ABLE TO BEAR STRESS.

THERE ARE SIGNIFICANT CHANGES IN TRADITIONAL FAMILY STRUCTURES AND ROLES.

THE AMERICAN FAMILY, AS WE HAVE KNOWN IT EARLIER IN THIS CENTURY, HAS FALLEN APART.

IN 1965 11.3% OF AMERICAN CHILDREN LIVED IN SINGLE-PARENT HOMES. BY 1987 21% OF AMERICANS UNDER 18 LIVED IN HOMES WITH A SINGLE PARENT.

DIVORCE, REMARRIAGE, DESERTION BY ONE PARENT OR THE OTHER.... ALL THIS HAS TORN FAMILIES APART, AND LEAD TO THE RESTRUCTURING OF FAMILIES IN NEW, SKELETAL, AND OFTEN DYSFUNCTIONAL FORMATIONS.

GENERATIONAL LINES ARE BLURRED BECAUSE GRANDMOTHER, MOTHER AND GRANDCHILD ALL HAVE CHILDREN BEING RAISED TOGETHER.

PARENTS INCREASINGLY DON'T ASSUME PARENTAL FUNCTIONS. IN SOME CASES THIS IS BECAUSE THEY ARE TOO YOUNG, - CHILDREN HAVING CHILDREN, BUT IN OTHER CASES THE PARENTS MANIFEST ILL-HEALTH, PERSONAL EMOTIONAL TRAUMA, AND THE INABILITY, OR EVEN UNWILLINGNESS TO COPE.

AS THE MIDDLE CLASS [redacted] SHRINKS, LARGER NUMBERS OF FAMILIES HAVE FEWER RESOURCES FOR SURVIVAL.

AND AS NUCLEAR FAMILIES BREAK DOWN, THE NEXT LEVEL OF SUPPORT --EXTENDED FAMILIES AND NEIGHBORHOODS-- SUFFER SIMILAR DISINTEGRATION IN A MORE URBANIZED, MORE MOBILE, MORE ANONYMOUS AMERICAN CULTURE.

THIS MEANS THAT WITH EACH PASSING YEAR, AMERICAN CHILDREN AND ADOLESCENTS HAVE LESS AND LESS CONTACT WITH ADULTS.

PARENTS WORK, RELATIVES AND NEIGHBORS MOVE AWAY OR ARE DISINTERESTED, YOUNGSTERS ARE LEFT ALONE.

THE AVERAGE CHILD SPENDS LESS THAN AN HOUR A DAY WITH HER OR HIS MOTHER, AND LESS THAN 5 MINUTES WITH THE FATHER. AND MANY DON'T HAVE ONE PARENT AROUND AT ALL.

ONLY 9% OF CHILDREN IN THE U.S. LIVE WITHIN WALKING DISTANCE OF GRANDPARENTS

EVEN WHEN BOTH PARENTS ARE PRESENT WE SEE AN ALARMING TENDENCY TO PASS THE BUCK OF PERSONAL RESPONSIBILITY.

PARENTS LEAVE TO THE SCHOOLS THE ENTIRE TASK OF EDUCATING THEIR CHILDREN, WHEN NOT LONG AGO PARENTS CLAIMED THE EDUCATION OF THEIR CHILDREN TO BE THEIR PRIVILEGE AND OBLIGATION, EVEN IF SHARED WITH THE SCHOOLS.

CHILDREN LIVE IN THEIR OWN CULTURE, REMOTE FROM ADULTS, DOMINATED ONE YEAR BY TRANSFORMER TOYS, THE NEXT BY CABBAGE PATCH DOLLS, THE NEXT BY TEENAGE MUTANT NINJA TURTLES.

THEY LEAD LIVES DETACHED FROM PARENTAL CONCERN OR INTEREST, TURNING TO PEERS FOR THE GUIDANCE OR EVEN PLAYFUL COMPANIONSHIP THAT PARENTS AND GRANDPARENTS USED TO PROVIDE.

INTO THE VACUUM CREATED BY THE ABSENCE OF ADULTS HAVE MOVED TELEVISION, RADIO, MOVIES, AND VIDEOS, OFTEN WITH A CONSTANT MESSAGE OF SEX, VIOLENCE, AND GREED.

RELIGIOUS TEACHING AND ETHICAL VALUES, IF THEY ARE INSTILLED AT ALL, ARE NOW LEFT TO CHURCH OR SYNAGOGUE. . . OR MTV.

AS WE MOVE INTO THE LAST DECADE OF THE TWENTIETH CENTURY, OUR NATION HAS YET TO ENACT A NATIONAL YOUTH AGENDA THAT

ADDRESSES THE NEEDS OF ADOLESCENTS COMPREHENSIVELY. EXISTING SERVICE DELIVERY SYSTEMS DO NOT FUNCTION IN WAYS THAT CHERISH AND PROVIDE FOR ADOLESCENTS AND THEIR FAMILIES. IT IS TIME TO RE-EXAMINE THE WAYS IN WHICH WE LOOK AT ADOLESCENTS AND THEIR SPECIAL HEALTH PROBLEMS -- TO REALLOCATE RESOURCES AND TO REDESIGN SERVICE DELIVERY SYSTEMS IN WAYS THAT HELP ALL OF OUR YOUNG PEOPLE, AND THEIR FAMILIES, COPE WITH THE CHALLENGES ASSOCIATED WITH BECOMING WELL-EDUCATED AND HEALTHY CITIZENS.

WHAT CAN WE DO?

WELL, I'VE GIVEN THIS A LOT OF THOUGHT, ESPECIALLY IN THE LAST FEW WEEKS WHEN I HAVE SPENT SO MUCH TIME WITH ADOLESCENTS, INTERVIEWING THEM IN CONNECTION WITH MY COMING NBC TV PRIMETIME SPECIAL ON ADOLESCENT HEALTH.

I'LL MAKE A FEW SUGGESTIONS, BASED UPON THE EYE-OPENING FILMING OF THE LAST FEW WEEKS, BASED UPON MY YEARS AS A SURGEON OF CHILDREN AND ADOLESCENTS, AND BASED UPON MY EXPERIENCE AS YOUR SURGEON GENERAL.

IN THAT LAST CAPACITY, ALTHOUGH I MAY HAVE RECEIVED PUBLIC ATTENTION FOR MY EFFORTS AGAINST AIDS, SMOKING, AND DRUNK DRIVING, I TAKE THE GREATEST SATISFACTION FOR AN INITIATIVE I WAS PRIVILEGED TO LEAD THAT REDESIGNED THE WAYS IN WHICH CHILDREN WITH SPECIAL HEALTH NEEDS -- SOME CALLED THEM HANDICAPPED CHILDREN-- COULD TAKE ADVANTAGE OF THE TANGLED WEB OF HEALTHCARE AND SOCIAL SERVICE AGENCIES THAT MIGHT HELP THEM.

THOSE OF US INVOLVED IN THIS INITIATIVE FOR SPECIAL NEEDS CHILDREN WANTED TO MAKE SURE THE SERVICES WERE PLANNED AROUND THE NEEDS OF THE PEOPLE WHO NEEDED THEM, RATHER THAN FORCING THE PEOPLE TO ADAPT TO THE SERVICES.

WE NEED THE SAME APPROACH FOR ADOLESCENT HEALTH PROBLEMS.

A FEW SIMPLE CONCEPTS SHOULD GUIDE US.

ALL OUR EFFORTS SHOULD BE:

FAMILY-CENTERED

COMMUNITY-BASED

CULTURALLY SENSITIVE

COORDINATED

CONFIDENTIAL

ADEQUATELY FINANCED.

FIRST, FAMILY-CENTERED:

EVEN THOUGH THE BELEAGUERED AMERICAN FAMILY IS OFTEN UNLIKE THAT IDEAL FAMILY OF THE STORY BOOKS, WE NEED TO DEAL WITH THE FAMILIES OF ADOLESCENTS, IN THEIR VARIOUS PERMUTATIONS, THE WAY WE FIND THEM, NOT THE WAY WE WOULD WISH THEM TO BE.

EVEN THOUGH FRAGMENTED, THE FAMILY IS THE CONTINUOUS PRESENCE IN THE LIFE OF THE ADOLESCENT.

FAMILIES, EVEN IN UNUSUAL FORMS, SHOW A STEELY RESILIENCE. IN WHATEVER SERVICES WE OFFER THE ADOLESCENT, WE MUST INCLUDE THE FAMILY. IN THE DEVELOPMENT AND APPLICATION OF POLICIES THAT AFFECT ADOLESCENT HEALTH CARE. SERVICES MUST BE FLEXIBLE AND RESPONSIVE TO FAMILIES.

WE NEED TO VIEW FAMILIES AS PRIMARY CARE PROVIDERS, AND GIVE THEM THE INFORMATION AND SUPPLIES THEY NEED TO DO THIS JOB.

WE NEED TO PAY HEED TO THE SINGLE PARENT FAMILIES OR AGGREGATE FAMILIES.

IF WE FIND FAMILIES WEAK, WE NEED TO STRENGTHEN THEM. WE NEED TO STRENGTHEN PARENTING SKILLS, REMEMBERING THAT IN SOME DYSFUNCTIONAL FAMILIES THE PARENT ROLE MAY BE ASSUMED BY AN OLDER SIBLING OR EVEN A SURROGATE ADULT.

FURTHERMORE, OUR CONCERN FOR FAMILIES MUST ENCOMPASS AN AFFIRMATION OF BASIC VALUES. HEALTH IS A MATTER OF THE SPIRIT AS WELL AS THE BODY. PROVISION OF A SPIRITUAL, A RELIGIOUS DIMENSION AMONG THE SERVICES OFFERED ADOLESCENTS AND THEIR FAMILIES WILL REAP LASTING REWARDS.

OUR CONCERN FOR ADOLESCENTS MUST BE

CULTURALLY SENSITIVE:

SERVICES NEED TO BE SENSITIVE TO DIFFERENT CULTURAL VALUES AND CUSTOMS. FOR EXAMPLE, MORE THAN 80% OF CHILDREN WITH HIV INFECTION ARE BLACK OR HISPANIC. SERVICES MUST FOCUS ON THE STRENGTHS AND NEEDS OF THESE GROUPS. MINORITY LEADERS SHOULD BE CENTRAL IN PLANNING AND STARTING SYSTEMS OF SERVICES FOR CHILDREN AND THEIR FAMILIES.

EVEN AFTER A GENERATION OF LEGISLATIVE, JUDICIAL AND PERSONAL EFFORTS TO ELIMINATE RACIAL INEQUALITY, AMERICA IS STILL PLAGUED BY RACISM, AND THERE ARE MANY WHO SEE ETHNIC HOSTILITY AND DISCRIMINATION ONLY INCREASING IN THE YEARS IMMEDIATELY BEFORE US.

DESPITE THE FACT THAT OUR COMMUNITIES ARE MORE CULTURALLY DIVERSE, SOCIAL INSTITUTIONS HAVE NOT ADAPTED TO THESE CHANGES. PROFESSIONAL INSENSITIVITY TO CULTURAL DIFFERENCES AND LANGUAGE BARRIERS IMPEDE ACCESSIBILITY TO SERVICES FOR CULTURALLY DIFFERENT FAMILIES AND ADOLESCENTS.

AS WE KEEP OUR FINGER ON THE PULSE OF THE FAMILY, AS WE ARE SENSITIVE TO CULTURAL DIFFERENCES, WE NEED TO GROUND OUR SERVICES IN THE COMMUNITY.

COMMUNITY-BASED SERVICES ARE THE KEY TO WINNING THE STRUGGLE AGAINST ADOLESCENT HEALTH PROBLEMS.

OUR COUNTRY IS RECOGNIZED INTERNATIONALLY FOR SOPHISTICATED TERTIARY CARE AND TECHNOLOGICAL ADVANCES; YET WE LACK ACCESS AND EQUITY FOR BASIC SERVICES AT THE FAMILY AND COMMUNITY LEVEL. WE ARE THE ONLY DEVELOPED NATION THAT DOES NOT GUARANTEE HEALTH CARE TO EVERY CITIZEN, WITH THE EXCEPTION OF SOUTH AFRICA.

SERVICES NEED TO BE PROVIDED IN OR NEAR THE HOME COMMUNITIES OR NEIGHBORHOODS OF CHILDREN AND THEIR FAMILIES. FAMILIES SHOULD NOT HAVE TO TRAVEL LONG DISTANCES FOR SERVICES. AND WHENEVER POSSIBLE, CHILDREN SHOULD BE CARED FOR AT HOME RATHER THAN IN A HOSPITAL.

I HAVE BECOME CONVINCED THAT FINDING THE RIGHT PLACE FOR ADOLESCENT HEALTH CARE WILL WIN HALF THE BATTLE.

EVEN WHEN ADOLESCENTS DECIDE TO SEEK A PHYSICIAN, FINDING A DOCTOR IS USUALLY A LOST CAUSE FOR MANY OF THEM.

I SPENT MUCH OF MY PROFESSIONAL LIFE MAKING SURE THAT CHILDREN WITH SURGICAL PROBLEMS CONTINUED TO RECEIVE GOOD COMPREHENSIVE CARE IN THE ADULT WORLD, SO I KNOW THAT ONE OF THE PERSISTENT PROBLEMS OF AMERICAN MEDICINE IS THE DIFFICULTY OF TRANSITION BETWEEN PEDIATRIC AND ADULT MEDICAL CARE.

SOME ADOLESCENTS DON'T LIKE TO KEEP GOING TO THEIR PEDIATRICIANS, THE "BABY DOCTOR", AND SOME PEDIATRICIANS ARE GLAD, FROM A PROFESSIONAL IF NOT PERSONAL POINT OF VIEW, TO SEE THEM MOVE ON.

OTHER ADOLESCENTS ARE RELUCTANT TO CHANGE, WHILE SOME PEDIATRICIANS FEEL TOO MUCH OF A PROPRIETARY INTEREST IN THEIR GROWING PATIENTS, AND CLING TO ADOLESCENTS WHO WOULD BE BETTER SERVED IN AN ADULT PRACTICE.